Vision Insurance Enrollment/Change Form

AMERITAS LIFE INSURANCE CORP.
5900 O Street, Lincoln, NE 68510
MAILING ADDRESS:
PO BOX 81889, LINCOLN, NE 68501
800-659-2223/ FAX (402)465-6133

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.

Name of Employer/Plan Sponsor North Dakota Public Employees Retirement System	Group/Plan Number **350308**
Agency/Department Name	Agency/Department Number

This change is due to:			Effective Date of Coverage or Change:
☐ Initial Eligibility Following Hire	☐ Cancel Coverage	☐ Change Agency From_____ to_____	
☐ Annual Enrollment	☐ Termination	☐ Loss of Other Coverage	
☐ Late Entrant Due to Change in Family Status*	☐ Add Dependent	☐ Address Change	
	☐ Delete Dependent	☐ Retirement	

**A late entrant is an individual who is first enrolling for vision coverage after the first available opportunity.*

Employee Information

Employee Name *(last, first, middle initial)*	☐ Female ☐ Male	Date of Birth	Social Security #
Employee Address *(street address, city, state, zip code)*	☐ Single ☐ Married	Telephone Work Home	

Elect Coverage

☐ Employee Only ☐ Employee + Spouse
☐ Employee + Child(ren) ☐ Employee + Family

Waive Coverage

IF YOU DO NOT WANT COVERAGE< COMPLETE THIS WAIVER SECTION.
I have been given the opportunity to apply for Group Vision Insurance offered by the employer, and have decided not to accept the offer for (check all that apply: ☐ myself ☐ spouse only ☐ child(ren) only ☐ myself and entire family
because: ☐ I have other coverage through my spouse's employer ☐ I have other individual coverage ☐ Other _____
Should I desire to apply for vision insurance in the future, I realize that a "late entrant" penalty may be applied.

Dependent Information Complete for covered spouse and each covered child. Attach separate sheet if more room is needed.

Dependent Name *(last, first, middle initial)*	Relationship to Employee	Gender (F or M)	Date of Birth	Marital Status*	Child Status**	Add or Delete

** For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, Legally Separated.*
*** For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.*

Other Vision Coverage Information Complete *if you and/or any dependent have vision coverage with another insurer or carrier.*

Employee/Dependent Name *(last, first, middle initial)*	Name and Address of Other Vision Insurer/Carrier	Policy/Plan Number	Effective Date	Other Vision Coverage Type
				☐ Single ☐ Family
				☐ Single ☐ Family

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium for the elected coverage
- To the best of my knowledge and belief, the information I have provided on this form is correct
- I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing materially false or misleading information, commits a fraudulent act, which is a crime
- I understand my coverage begins on the effective date assigned by Ameritas, provided I am actively at work

Employee's Signature	Date Signed